OFFICIAL

Attachment 4.19-D
Part I

86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the residential health care facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified by the State Commissioner of Health based on the initial submission of base year data and reports will be construed to represent a provisional rate until such audit is performed and completed, at which time such after or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted by the records of residential health care facilities, in a time, manner and place to be determined by the State Department of Health.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or form the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit the residential health care facility shall be afforded a closing conference. The residential health care facility

OFFICIAL

may appear in person or by anyone authorized in writing to act on behalf of the residential health care facility. The residential health care facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The residential health care facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the residential health care facility initiates a bureau review by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees and such other material as the provider wishes to submit in its behalf and forwarding all material documentation in support of the residential health care facility's position.

(f) The residential health care facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate citation to applicable law, regulation or policy. The audit finding as adjusted in accordance with the determination of the bureau review shall be final, except that the residential health care facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the residential health care facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement

OFFICIAL

of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the residential health care facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the residential health care facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the residential health care facility.

(2) The issues and documentation presented by the residential health care facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the residential health care facility to prove by substantial evidence that the items therein contained are incorrect. At such hearing, the residential health care facility shall have the obligation to initially present such evidence in support of its position. Failure to do so shall result in termination of the hearing.

OFFICIAL

Attachment 4.19-D
Part I

(4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and State Administrative Procedure Act.

(5) At the conclusion of the hearing the residential health care facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall be come part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.

86-4
supersedes
82-30

[redacted] Approval Date JUL. 29 1987 Effective Date JAN. 1 1986

OFFICIAL

Attachment 4.19-D
Part I

86-2.8 Patient days. (a) A *patient day* is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

(d) Reserved bed patient days shall be computed separately from patient days. A *reserved bed patient day* is the unit of measure denoting an overnight stay away from the residential health care facility for which the patient, or patient's third-party payor, provides per diem reimbursement when the patient's absence is due to hospitalization or therapeutic leave.

(e) In computing reserved bed patient days, the day of discharge from the residential health care facility shall be counted, but not day of readmission.

86-4
supersedes
82-30

Approval Date JUL. 29 1987 Effective Date JAN. 1 1988

- Deleted -

OFFICIAL

86-2.10 Computation of basic rate. (a) Definitions. For purposes of this section, the following definitions shall apply:

(1) Direct price shall mean the monetary amount established for the direct component of the rate, based on the direct costs of all facilities after application of the regional direct input price adjustment factor, divided by patient days and the average statewide case mix index.

(2) Indirect price shall mean the monetary amount established for the indirect component of the rate, based on the indirect costs for each facility in a peer group, after application of a regional indirect price adjustment factor, divided by total peer group patient days.

(3) Peer group shall mean a set of facilities distinguished by like characteristics which are grouped for purposes of comparing costs and establishing payment rates using such criteria as affiliation (i.e., hospital-based or freestanding) case mix index (i.e., high intensity, case mix index greater than .83, or low intensity, case mix index less than or equal to .83), and size (i.e., less than 300 beds or 300 or more beds).

(4) Cost center shall mean categories into which related costs are grouped in accordance with and defined in Part 455 of this Title.

(5) Case mix index shall mean the numeric weighting of each patient classification group in terms of relative resource utilization as specified in Appendix 13-A, infra.

(6) Rate shall mean the aggregate governmental payment to facilities per patient day as defined in section 86-2.8 of this Subpart, for the care

of medicaid patients which shall include a Direct, Indirect Non-Comparable and Capital component.

(7) Operating portion of the rate shall mean the portion of the rate consisting of the Direct, Indirect and Non-Comparable components after application of the roll factor promulgated by the department.

(8) Role Factor shall mean the cumulative result of multiplying one year's trend (inflation) factor times one or more other years trend factor(s) which is used to inflate costs from a base period to a rate period.

(9) Capital Costs shall mean costs reported in the Depreciation, Leases and Rentals, Interest on Capital Debt and/or Major Movable Equipment Depreciation Cost Centers, as well as costs reported in any other cost center under the major natural classification of Depreciation, Leases and Rentals on the facilities annual cost report (RHCF-4).

(10) Base shall mean, as applicable to cost or price, a minimum cost or price.

(11) Ceiling shall mean, as applicable to cost or price, a maximum cost or price.

(12) Corridor shall mean the difference between a base and a ceiling.

(13) Hospital based shall mean as follows:

(i) For facilities receiving initial operating certificates prior to January 1, 1983, hospital based shall mean those facilities that are considered by the federal Health Care Financing

Administration (HCFA) to be hospital based or hospital rated (as pertaining to cost allocation) and which derive and report costs on the basis of a Medicare cost allocation methodology from an affiliated hospital.

(ii) For facilities receiving operating certificates after January 1, 1983 the commissioner shall review and determine whether or not such facilities are hospital based utilizing the following criteria:

(a) the nature of any construction approval received pursuant to Section 2802 of the Public Health Law;

(b) the nature of any establishment approval received pursuant to Section 2801-a of the Public Health Law;

(c) the architectural configuration for the residential health care facility unit as related to the hospital physical plant;

(d) the method and amount of cost allocation;

(e) whether a determination hat such a facility is hospital based would result in the efficient and economic operation of such facility.

(b) (1) The rate for 1986 and subsequent rate years shall

(i) be computed on the basis of allowable fiscal and statistical data submitted by the facility for the fiscal year ending December 31, 1983 as contained in parts I, II, III and IV of the facility's annual cost report (RHCF-4) and for hospital based facilities, the annual cost report (RHCF-2) and the institutional cost report of its related hospital.

86-4
superseded

JAN 1 1986

Attachment 4.19-D
Part I

(ii) Consist of the following four separate and distinct components, as defined in this section.

(a) Direct

(b) Indirect

(c) Non-Comparable

(d) Capital

(2) The operating portion of the rate for 1986 and subsequent rate years shall consist of the sum of the Direct, Indirect and Non-Comparable Components of the rate determined in accordance with this section trended to the rate year by the applicable roll factor promulgated by the department.

(3) Allocation and Adjustments of Reported Costs.

(i) The computation of the rate for 1986 and for subsequent rate years shall incorporate the use of the single stepdown method of cost allocation as defined in section 451.249 of Article 9 of Subchapter A of Chapter V of this Title.

(ii) Individual discrete ceilings shall be applied to renumeration for the facility's administrator, assistant administrator and operator as specified in Appendix 6a infra.

(iii) Reported Costs of 1983 shall be adjusted through the apportionment of retroactive adjustments due to operating appeals which were as a result of significant increases in staff specifically mandated by the Commissioner. Such adjustments shall be limited to

86-4
supersedes